DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF PLAN SURVEYS

1115 WAIVER SURVEY

TECHNICAL ASSISTANCE GUIDE

CONTINUITY OF CARE

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this December 12, 2011 Technical Assistance Guide renders all other versions obsolete.

1115 WAIVER CONTINUITY OF CARE (CC) TAG

Continuity of Care Requirements

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1115 WAIVER CONTINUITY OF CARE (CC) TAG

Requirement CC-001: The Health Plan maintains the methodologies and processes used to coordinate medically necessary services within the provider network.

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management

1. Utilization Management (UM) Program - Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures.

DHCS GMC Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management

1. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Contractor shall ensure that all contracted health care practitioners and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

DHCS Two-Plan Boilerplate Contract, Exhibit A, Attachment 9, Access & Availability

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

DHCS GMC Boilerplate Contract, Exhibit A, Attachment 9 – Access & Availability

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with 28 CCR 1300.67.2 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall ensure that contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 10 – Scope of Services

3. Initial Health Assessment (IHA)

An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic, and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision6 below.
B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.
C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.
D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

4. Health Risk Stratification and Assessment for SPD Beneficiaries

Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be

a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and MMCD Policy Letter 11-007.

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

A. Provision of IHAs for Members under Age 21

1) For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.
2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
3) Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each child at the time of enrollment is accomplished at the IHA. The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate IHEBA.

6. Services for Adults

A. IHAs for Adults (Age 21 and older)

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

8. Services for All Members

A. Health Education

10) Contractor shall ensure that all new Members complete the individual health education behavioral assessment within 120 calendar days of enrollment as part of the initial health assessment; and that all existing Members complete the individual health education behavioral assessment at their next non-acute care visit. Contractor shall ensure: 1) that primary care providers use the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the individual health education behavioral assessment; and 2) that the individual health education behavioral assessment tool is: a) administered and reviewed by the primary care provider during an office visit, b) reviewed at least annually by the primary care provider with Members who present for a scheduled visit, and c) re-administered by the primary care provider at the appropriate age-intervals.

1115 WAIVER CONTINUITY OF CARE (CC) TAG

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 11 – Case Management & Coordination of Care

1. Comprehensive Case Management Including Coordination of Care Services

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

A. Basic Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include:
   1. Initial Health Assessment (IHA)
   2. Initial Health Education Behavioral Assessment (IHEBA)
   3. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
   4. Direct communication between the provider and Member/family
   5. Member and family education, including healthy lifestyle changes when warranted
   6. Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.

B. Complex Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum:
   1. Basic Case Management Services
   2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
   3. Intense coordination of resources to ensure member regains optimal health or improved functionality
   4. With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPDs must include the concepts of Person-Centered Planning.

D. Person-Centered Planning for SPD Beneficiaries
   1. Upon the enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.
   2. Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.
   3. Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4. Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

2. Discharge Planning and Care Coordination

Contractor shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- QA Director
- Participating Providers
- Staff responsible for discharge planning
- Staff responsible for assisting enrollees in transitioning care

DOCUMENTS TO BE REVIEWED

- Case management program descriptions regarding continuity of care and related policies and procedures, including:
    - Continuity, timeliness and coordination of care between and among providers (including mental health providers, specialists, facilities, medical groups, case management staff, etc.);
    - case management, including basic case management and comprehensive case management, case management staff;

  - case management team structure and processes;
  - Person-Centered Planning;
  - timely communication of clinical information among providers;
  - transitions of care, including completion of covered services by a terminated provider to enrollee who was receiving services and completion of covered services by a nonparticipating provider to a newly covered enrollee;
  - protecting confidentiality of enrollee health information;
  - specialty referrals;
  - screening for and co-management of co-existing medical and mental health conditions; etc.
- Health risk assessment survey
- Procedures and tools to complete health risk stratification
- Policies and procedures regarding provision of IHA and IHEBA
- Policies and procedures regarding follow up on missed IHAs
- Policies and procedures to ensure arrangement of follow up services identified during the IHA
- Enrollee referral policies, procedures, and processes
- Referral monitoring and tracking records, logs and reports
- Provider surveys (especially addressing satisfaction with feedback received by PCPs following referrals to specialists and referral timeliness)
- Practitioner and provider manuals
- Member Services Guide
- Reports of continuity and coordination of care measures, results, analyses, conclusions and actions to be taken
- Notification letter templates to enrollees requesting transitional care
- Reports on number, type and disposition of transitional care cases
- Member/Customer Service desk procedures on responding to inquiries about transition of care
- Corrective action plans and documentation of interventions and results
- Delegated entity oversight reports
- Plan's Web site

CC-001 - Key Element 1:

1. **The Plan assures that contracting providers schedule and provide an Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA) within the required timeframes.**
   DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9, Item 3 (A); Attachment 10 – Scope of Services, Item 3 (B); Item 4; Item 6 (A)(1); Item 8 (A)(10); Attachment 11 – Case Management & Coordination of Care, Item 1 (A) through (D)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have procedures to apply health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex healthcare needs within 44 days of enrollment?			
1.2 Does the Plan have procedures to administer the DHCS-approved health risk assessment survey within 45 days (for beneficiaries deemed to be at higher health risk) or 105 days (for those determined to be a lower health risk)?			
1.3 Does the Plan have procedures to assure that contracting providers provide an IHA within required timeframes? - Members < 18 months, within 60 calendar days - Members > 18 months, within 120 calendar days			
1.4 Does the Plan have procedures in place to ensure follow up on missed IHA appointments?			
1.5 Does the Plan have procedures in place to ensure that arrangements are made for follow up services that reflect the findings or risk factors discovered during the IHA and IHEBA?			
1.6 Does the Plan require the Staying Healthy assessment tool or alternative DHCS approved tool is used for the IHEBA?			
1.7 Does the Plan require that primary care providers review the IHEBA with members at least annually during a scheduled visit?			

CC-001 - Key Element 2:

2. The Plan has established procedures for providing comprehensive and complex case management services necessary to meet SPD member needs.
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 11 – Case Management & Coordination of Care, Item 1 (A) through (D)

Assessment Questions	Yes	No	N/A
2.1 Has the Plan established policies and procedures for identifying members who may benefit from Complex Case Management services?			
2.2 Has the Plan established policies and procedures for managing acute and/or chronic illness (Complex Case Management) in collaboration with the Primary Care Provider?			
2.3 Does the Plan utilize a multidisciplinary case management team (to comprehensively assess and evaluate member needs, initiate and coordinate required care, and otherwise provide effective case management for each member)?			
2.4 Has the Plan implemented and communicated Person-Centered Planning for SPD beneficiaries?			

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CC-001 - Key Element 3:

3. The Plan has established procedures for coordinating care provided to members in all settings and among all provider types (PCP, specialty practitioners, facilities, institutions, etc.)
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 5 – Utilization Management, Item 1 (F); Attachment 11 – Case Management & Coordination of Care, Item 1 (A) through (D); Item 2 (A) through (D)

Assessment Questions	Yes	No	N/A
3.1 Has the Plan established policies and procedures for coordinating medically necessary services between providers (within the network)?			
3.2 Has the Plan developed and implemented an adequate system for tracking all referrals and follow-up care?			
3.3 Does the referral tracking system including non-contracting providers?			
3.4 Does the referral tracking system include authorized, denied, deferred and modified referrals as well as timeliness of referrals?			
3.5 Has the Plan established procedures and guidelines for ensuring coordination of discharge planning from inpatient facilities?			
3.6 Has the Plan established and implemented policies and procedures to ensure the continuity of care from the Ambulatory Care setting to the inpatient care setting or other care settings as necessary?			

End of Requirement CC-001: The Health Plan maintains the methodologies and processes used to coordinate medically necessary services within the provider network.

1115 WAIVER CONTINUITY OF CARE (CC) TAG

Requirement CC-002: The Health Plan ensures the coordination of medically necessary services outside the network (specialists).

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management

1. Utilization Management (UM) Program - Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures.

DHCS GMC Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management

1. Utilization Management (UM) Program - Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Contractor shall ensure that all contracted health care practitioners and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 6, Provider Network

1. Network Capacity

Contractor shall maintain a provider network adequate to serve sixty percent (60%) of all Eligible Beneficiaries, including SPD beneficiaries, in the proposed county and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation, if Enrollments do not achieve seventy-five (75%) of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.

DHCS Two-Plan Boilerplate Contract, Exhibit A, Attachment 6, Provider Network

6. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code section 14182(c)(2).

DHCS GMC Boilerplate Contract, Exhibit A, Attachment 6, Provider Network

6. Specialists

Contractor shall provide accessibility to medically required specialists who possess a copy of a valid diploma or certificate of satisfactory completion of a specialty residency or fellowship program accredited by the Accreditation Council of Graduate Medical Education (ACGME), through contracting or referral. Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with W & I Code section 14182(c)(2). Contractor shall provide a record/tracking mechanism for each authorized, denied, or modified referral. In addition, Contractor shall offer second opinions by specialists to any Member upon request.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9 – Access & Availability

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

16. Out-of-Network Providers

A. If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.
B. Contractor shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.
C. For newly enrolled SPD beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an out-of-network provider with whom

they have an ongoing relationship if there are no quality of care issues with the provider and the provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by the Contractor identifying a link between a newly enrolled SPD beneficiary and an out-of-network provider using FFS utilization data provided by DHCS.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 11 – Case Management & Coordination of Care

3. Targeted Case Management Services

Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

If a Member is receiving TCM services as specified in Title 22 CCR Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM provider that are Covered Services under the Contract.

If Members under age 21 are not accepted for TCM services, see Exhibit A, Attachment 10, Provision 4, Contractor shall ensure the Members' access to services comparable to EPSDT TCM services.

5. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6 through 17 below.

18. Excluded Services Requiring Member Disenrollment

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll and receive the following services through the Medi-Cal FFS program until the date of disenrollment is effective.

A. Long Term Care (LTC)

Long-term care (LTC) is defined as care in a facility for longer than the month of admission plus one month. LTC services are not covered under this Contract. Contractor shall cover Medically Necessary nursing care provided from the time of admission and up to one month after the month of admission.

Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities, and Intermediate Care Facilities. Contractor shall base decisions on the appropriate level of care on the

definitions set forth in Title 22 CCR Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22 CCR Sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22 CCR Section 51003(e).

Upon admission to an appropriate facility, Contractor shall assess the Member's health care needs and estimate the potential length of stay of the Member. If the Member requires LTC in the facility for longer than the month of admission plus one month, Contractor shall submit a disenrollment request for the Member to DHCS for approval. Contractor shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective.

An approved disenrollment request will become effective the first day of the second month following the month of the Member's admission to the facility, provided the Contractor submitted the disenrollment request at least 30 calendar days prior to that date. If the Contractor submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Upon the disenrollment effective date, Contractor shall ensure the Member's orderly transfer from the Contractor to the Medi-Cal FFS program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Contractor to the Medi-Cal FFS provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.

Admission to a nursing facility of a Member who has elected hospice services as described in Title 22 CCR Section 51349, does not affect the Member's eligibility for enrollment under this Contract. Hospice services are Covered Services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- Individual responsible for negotiating agreements with non-network providers

DOCUMENTS TO BE REVIEWED

- Policies and procedures for identifying members requiring Targeted Case Management (TCM)
- Policies and procedures for coordinating members healthcare with TCM providers
- Policies and procedures for coordinating care with providers outside the network

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CC-002 - Key Element 1:

1. The Plan has established procedures for providing case management and coordination of care for members who require care outside the network.
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9 – Access & Availability, Item 16 (A); Attachment 11 – Case Management & Coordination of Care, Item 3 and Item 5

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and processes in place to identify members who require Targeted Case Management (TCM) services?			
1.2 Does the Plan ensure that members requiring Targeted Case Management are referred to a Regional Center or local governmental health program?			
1.3 Does the Plan have policies and procedures for coordinating member's healthcare with a TCM provider?			

CC-002 - Key Element 2:

2. The Plan has established procedures for coordinating medically necessary services provided to members outside the network and among all provider types (PCP, specialty practitioners, facilities, institutions, etc.)
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 6 – Provider Network, Item 1 and Item 6; Attachment 9 – Access and Availability, Item 1 and Item 16; Attachment 11 – Case Management & Coordination of Care, Item 5 and Item 18 (A)

Assessment Questions	Yes	No	N/A
2.1 Has the Plan established policies and procedures for coordinating medically necessary services between providers outside the network?			
2.2 Has the Plan implemented procedures to identify individuals who need or are receiving services from out-of-plan providers and/or programs in order to ensure coordinated care?			
2.3 Has the Plan established and implemented procedures for arranging for seldom-used specialty services outside the network when a medically necessary covered service is not available in the network?			
2.4 Does the Plan have policies and procedures outlining the process for brining providers into the network?			
2.5 Has the Plan established and implemented procedures for ensuring the orderly transfer of members to a fee-for-service Long Term Care facility that provides the level of care most appropriate to the member's condition?			

End of Requirement CC-002: The Health Plan ensures the coordination of medically necessary services outside the network (specialists).

1115 WAIVER CONTINUITY OF CARE (CC) TAG

Requirement CC-003: The Health Plan ensures the coordination of special arrangement services including but not limited to, California Children's Services, Child Health and Disability Prevention, Early Start, and Regional Centers.

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 11 – Case Management & Coordination of Care

8. Services for Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are defined as "those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally".

Contractor shall implement and maintain a program for CSHCN which includes, but is not limited to, the following:

A. Standardized procedures for the identification of CSHCN, at enrollment and on a periodic basis thereafter;
B. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as PCP, standing referrals, or other methods as defined by Contractor;
C. Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all Medically Necessary follow-up services are documented in the medical record, including needed referrals;
D. A program for case management or care coordination for CSHCN, including coordination with other agencies which provide services for children with special health care needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency); and
E. Methods for monitoring and improving the quality and appropriateness of care for children with special health care needs.

9. California Children Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:
    1) Ensure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;

2) Assure that contracting providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Contractor's network; and only from the date of referral;
3) Enable initial referrals of Member's with CCS eligible conditions to be made to the local CCS program by telephone, same day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.
5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.
6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

10. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.
B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).
C. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.
D. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS Waiver program administered by the State Department of Developmental Services (DDS).

    If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled

in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with developmental disabilities.

11. Early Intervention Services

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

12. Local Education Agency Services

Local Education Agency (LEA) assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22 CCR Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020 are not covered under this Contract. However, the Contractor is responsible for providing a Primary Care Physician and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's Primary Care Physician cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

13. School Linked CHDP Services

A. Coordination of Care

Contractor shall maintain a "medical home" and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

B. Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Cooperative arrangements (e.g. Subcontracts) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements

shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.

2) Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.
3) Referral protocols/guidelines between the Contractor and the school sites, which merely screen, for the need of CHDP services, including strategies for the Contractor to follow-up and document if services are being provided to the Member within the required State and Federal time frames.
4) Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

18. Excluded Services Requiring Member Disenrollment

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll and receive the following services through the Medi-Cal FFS program until the date of disenrollment is effective.

A. Long Term Care (LTC)

Long-term care (LTC) is defined as care in a facility for longer than the month of admission plus one month. LTC services are not covered under this Contract. Contractor shall cover Medically Necessary nursing care provided from the time of admission and up to one month after the month of admission.

Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities, and Intermediate Care Facilities. Contractor shall base decisions on the appropriate level of care on the definitions set forth in Title 22 CCR Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22 CCR Sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22 CCR Section 51003(e).

Upon admission to an appropriate facility, Contractor shall assess the Member’s health care needs and estimate the potential length of stay of the Member. If the Member requires LTC in the facility for longer than the month of admission plus one month, Contractor shall submit a disenrollment request for the Member to DHCS for approval. Contractor shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective.

An approved disenrollment request will become effective the first day of the second month following the month of the Member's admission to the facility, provided the Contractor submitted the disenrollment request at least 30 calendar days prior to that date. If the Contractor submitted the disenrollment request less than 30 calendar days prior to that date,

disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Upon the disenrollment effective date, Contractor shall ensure the Member's orderly transfer from the Contractor to the Medi-Cal FFS program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Contractor to the Medi-Cal FFS provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.

Admission to a nursing facility of a Member who has elected hospice services as described in Title 22 CCR Section 51349, does not affect the Member's eligibility for enrollment under this Contract. Hospice services are Covered Services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- Case Management Manager
- Regional Center Liaison

DOCUMENTS TO BE REVIEWED

- Policies and procedures for identifying and referring members who may qualify for special arrangement services.
- Policies and procedures for care coordination for members receiving special arrangement services.
- Provide a list of all members eligible for: California Children's Services; Referral to Early Start or receiving early intervention; services for Developmentally Disabled

CC-003 - Key Element 1:

1. The Plan has established and implemented procedures to coordinate special arrangement services for SPD members as defined by the contract.
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 11 – Case Management & Coordination of Care, Item 9; Item 10; Item 11; Item 12; Item 13; and Item 18 (A)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have written policies and procedures for identifying and referring children with a California Children Services (CCS) eligible condition?			

Assessment Questions	Yes	No	N/A
1.2 Does the Plan ensure the coordination of services and joint case management between the Primary Care Physician, CCS specialty providers, and the local CCS program?			
1.3 Does the Plan have systems in place to identify and refer children who may be eligible to receive services from the Early Start Program and provide care coordination to ensure provision of medically necessary services?			
1.4 Does the Plan maintain a "medical home" for members and ensure the overall coordination of care and case management of members who obtain school-linked Child Health and Disability Prevention (CHDP) services through local school districts or sites?			
1.5 Has the Plan developed and implemented procedures for identification of members with developmental disabilities?			
1.6 Does the Plan demonstrate coordination with Regional Centers operating within the service area to assist developmentally disabled members in accessing services and solving problems?			
1.7 Does the Plan have a dedicated liaison to coordinate with each Regional Center operating within the Plan's service area?			
1.8 Has the Plan implemented procedures for identifying and referring members who may be eligible for referrals to community, local health department, or regional center services (including HIV/AIDS and other Waiver Programs, specialty mental health services, alcohol and substance abuse treatment, WIC, erectile dysfunction, etc.)?			

CC-003 - Key Element 2:

1. **The Plan has established and implemented procedures for providing comprehensive and complex case management and care coordination, both within and outside of the network, for Children with Special Health Care Needs (CSHCN).**
   DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 11 – Case Management & Coordination of Care, Item 8

Assessment Questions	Yes	No	N/A
2.1 Has the Plan implemented and maintained a program to identify and coordinate care for Children with Special Health Care Needs?			
2.2 Has the Plan implemented methods for ensuring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies for Children with Special Health Care Needs?			
2.3 Has the Plan implemented and maintained a program to identify and coordinate care outside the network with other agencies which provide services for Children with Special Health Care Needs?			

End of Requirement CC-003: **The Health Plan ensures the coordination of special arrangement services including but not limited to, California Children's Services, Child Health and Disability Prevention, Early Start, and Regional Centers.**

1115 WAIVER CONTINUITY OF CARE (CC) TAG

Requirement CC-004: The Health Plan ensures compliance with continuity of care requirements in Section 1373.96 of the Health & Safety Code

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9 – Access & Availability

2. Existing Patient-Physician Relationships

Contractor shall ensure that no traditional or safety-net provider, upon entry into the Contractor's network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible.

16. Out-of-Network Providers

B. Contractor shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.

C. For newly enrolled SPD beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an out-of-network provider with whom they have an ongoing relationship if there are no quality of care issues with the provider and the provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by the Contractor identifying a link between a newly enrolled SPD beneficiary and an out-of-network provider using FFS utilization data provided by DHCS.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit E, Attachment 1 – Definitions

102. Safety-Net Provider means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

121. Traditional Provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

CA Health and Safety Code sections 1373.96(a) and (b)

(a) A health care service plan shall at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b)(1) The completion of covered services shall be provided by a terminated provider to an enrollee who at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).
(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- QI Director
- Staff responsible for transition of care (both those assisting enrollees and those working with providers)

DOCUMENTS TO BE REVIEWED

- Policies and procedures regarding all types of transition of care
- Criteria for approving and/or denying transition of care requests
- Notification letter templates to enrollees requesting transitional care
- Reports on the number, type and disposition of transitional care cases
- Member/Customer Service computer screens and/or desk procedures on responding to inquiries regarding transition of care
- Corrective action plans and documentation of interventions and results
- Delegated entity oversight reports
- Enrollee materials describing transition of care

CC-004 - Key Element 1:

1. **The Plan has mechanisms to facilitate transitions of care (including enrollee notifications) when a) an individual in a course of treatment enrolls in the Plan, and b) when a medical group or provider is terminated from the network.**
   DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9 – Access & Availability, Item 2 and Item 16 (B) and Item (C); CA Health and Safety Code sections 1373.96(a) and (b)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an effective tracking and review mechanism for requests of continuity of care for new enrollees with current non-participating providers?			

Assessment Questions		Yes	No	N/A
1.2	Does the Plan have established policies and procedures for the safe transfer of care of new enrollees with acute, serious, or chronic health conditions who are currently receiving services from a non-participating provider to a participating provider?			
1.3	Does the Plan have established policies and procedures addressing planned and unplanned terminations of providers from its provider network?			
1.4	Do the Plan's policies and procedures address all provider types (PCPs, specialists, etc.)?			
1.5	Do the Plan's policies and procedures address enrollees receiving treatment for acute or chronic conditions?			
1.6	Does the Plan use adequate review criteria that meet community standards of practice to determine whether current enrollees' treatment/care is transferable to another provider without compromising quality of care?			
1.7	Does the Plan clearly define conditions/situations in which premature transfer of care may compromise quality of care?			
1.8	Do the Plan's policies and procedures address situations where an enrollee may be allowed to continue treatment with the previous provider for a specified period of time or for completion of covered services?			
1.9	Does the Plan have an effective mechanism for timely notification of all parties involved (enrollees, participating and non-participating providers) to facilitate safe transition of care?			
1.10	Does the Plan have established policies and procedures for bringing providers into their network?			

End of Requirement CC-004: The Health Plan ensures compliance with continuity of care requirements in Section 1373.96 of the Health and Safety Code.